The Division of Mental Retardation Services

Planning and Implementation Resource Manual

Table of Contents

SECTION ONE
PRE ADMISSION EVALUATION
PLAN OF CARE

What: The Pre-Admission Evaluation (PAE) provides the information necessary to determine an individual's programmatic eligibility for DMRS services. The Pre-Admission Evaluation also identifies the service, specific HCBS Waiver or ICF/MR, being requested. The Pre Admission Evaluation packet includes the following:

- Psychological Evaluation completed no more than 12 calendar months prior to admission into the Waiver and updated no more than 90 days prior to admission that indicates a primary diagnosis of mental retardation prior to age 18.
- Physical current within one year of the request date and signed by a physician.
- PAE form including the initial plan of care attached to the psychological and physical, signed by the physician.
- Evidence of financial eligibility.

The determination of eligibility is based on information contained in the psychological evaluation, physical and the assessment of the individual's capabilities and needs included in the PAE form. This assessment covers the following areas:

- Bathing
- Communication, Expressive
- Eating/Feeding
- Mobility by Ambulation or Wheelchair
- Orientation to Self
- Orientation to Place
- Prescription, Medication, Ability to Self-Administer
- Toileting and Toileting Hygiene
- Transfers
- Vision
- Need for Behavior Intervention
- Previous Habilitative Training for ADLs

Who: Person, Family, Friends and Legal Representative
DMRS Case Manager
Psychologist
Physician
TennCare PAE Staff

When: The Pre Admission Evaluation must be completed and approved by TennCare prior to enrollment into Waiver services.

Process:

What Happens	Who is Responsible
1. Obtain Documentation of Mental Retardation prior to the age of 18. Specifically, there must be evidence the person has an I.Q. of 70 or below and that it was present prior to the age of 18.	• DMRS Case Manager
2. Assess the person's needs using the ICAP and other information available to determine the person's needs and which Waiver will best meet his/her needs.	• DMRS Case Manager
3. Determine Medicaid eligibility.	• DMRS Case Manager • Person, Family, Friends and Legal Representative • Department of Human Services
4. Obtain copy of physical completed within the last year or schedule one.	• DMRS Case Manager • Person, Family, Friends and Legal Representative • Physician
5. Obtain a copy of psychological evaluation done within the last year or schedule one. If completed within last year but not within previous 90 days, update the current evaluation. Updates must be completed by the same person who completed the evaluation being updated. If updating is not possible, a new psychological must be obtained.	• DMRS Case Manager • Person, Family, Friends and Legal Representative • Psychologist
6. Complete the PAE form with the person/family and those who know the person well.	• DMRS Case Manager
7. Complete the Plan of Care (list of services needed).	• DMRS Case Manager
8. Submit the completed packet to the physician for signature.	• DMRS Case Manager • Person, Family, Friends and Legal Representative
9. Once physician has signed the packet, review it again for accuracy and submit to TennCare MR PAE unit for review.	• DMRS Case Manager
10. If PAE is approved, proceed with enrollment; e.g. complete financial eligibility, identify any providers in place, notify administrative services	• DMRS Case Manager

so that a cost plan can be generated.	
11. If PAE is denied, assist person/family with appeal or re-submit if appropriate.	• DMRS Case Manager

Other Important Things to Know:

- PAEs are completed to determine eligibility and can be completed at any time.
- An approved PAE does not guarantee enrollment.
- The Plan of Care that is part of the approved PAE authorizes services for the first 30 days. These are the only services that are authorized to be provided during this time.
- If new or increased services are needed within the first 30 days, they must be requested as part of an initial ISP or the PAE can be redone and resubmitted by the DMRS Case Manager prior to enrollment.
- PAEs cannot be amended once they have been approved.
- See Appendix A2 for list of who can complete the PAE

Provider Manual References:

- Chapter 1 "Eligibility, Enrollment and Disenrollment

Resources:

- PAE form (Included in Appendix A1)
- Instructions for completing the PAE. (Included in Appendix A2)

Training Available:

- There are no regularly scheduled training sessions but training by TennCare MR PAE unit staff is available by request.

SECTION TWO
INITIAL INDIVIDUAL SUPPORT PLAN

What: The Initial Individual Support Plan (ISP) is the first plan that is developed after enrollment into Waiver services.

Who: Person, Family, Friends and Legal Representative
DMRS Case Manager (For individuals enrolled in the Self Determination Waiver)
Agency Case Manager (For individuals receiving state funded services only)
Independent Support Coordinator (For individuals enrolled in the Arlington or Statewide Waiver)

When: The initial plan must be completed within thirty (30) calendar days from the date of enrollment which is the date that Medicaid Waiver services initially begin as shown on the Department of Human Services Forms 2350 and 2362.

Process:

What Happens	Who Is Responsible
1. Gather all available assessment and evaluation information including the original plan of care, physical, psychological evaluation, ICAP, risk assessment, historical information, etc.	• DMRS Case Manager , ISC or Agency Case Manager
2. Talk with the person to learn what is important to him/her in order to have a quality life. , close friends and family members and others who know and care about the person.	• DMRS Case Manager , ISC or Agency Case Manager
3. Talk with the legal representative, family, friends, and others who know and care about the person to learn what they feel is important for the person.	• DMRS Case Manager , ISC or Agency Case Manager
4. Explain the ISP and its purpose to the person, legal representative and family. a. The ISP and the planning process are person centered and should be include what is important to the person as well as include what others feel the person needs. b. The ISP is the document that describes what the person's life is like, what they want it to	• DMRS Case Manager , ISC or Agency Case Manager

What Happens	Who Is Responsible
be like, what they need to be healthy and safe, how all of that is going to happen and who is going to do it. c. Ensures the person is assisted in achieving a full life as a member of his/her community in ways that he/she prefers. d. It is the way everyone who knows and cares about the person and supports them stays accountable for what needs to be done. e. It includes planning and development of actions to maintain what is working. f. It looks at what is absent in the person's life to ensure they have what is important to them within the framework of health and safety, what needs to change and how to promote the needed/desired changes. g. It is a document that is required by federal regulation and supports the need for state and federal funding to pay for the services the person needs. h. It is reviewed by DMRS to ensure that it meets all applicable requirements and for authorization of services. i. Monitoring the ISP ensures that progress is made toward achieving the person's outcomes.	
5. Explain the planning process to the person, legal representative and family. a. The planning process begins with assessment of the person's skill, abilities and needs or re-assessment to determine progress in meeting previous outcomes, goals or actions. b. Pre-planning activities are designed to give the person, legal representative and family information about services and their rights as well as the opportunity to discuss what they want to have happen and any concerns they might have outside the presence of paid providers. It includes identification of personal outcomes, supports for daily life and risks.	• DMRS Case Manager , ISC or Agency Case Manager

What Happens	Who Is Responsible
c. Meeting with those who know and care about the person and support them to determine how their outcomes will be met, to identify goals for supports for daily life, how those will be met, planning for risk issues and identifying the services and supports needed to make the plan happen. d. Implementation of the ISP. e. Monitoring implementation. f. Amendments when needed.	
6. Review the person's rights and responsibilities, including appeal rights and complaint resolution procedures. A compilation of individual rights from Chapter 2 of the DMRS provider manual is included in Appendix B1.	• DMRS Case Manager , ISC or Agency Case Manager
7. Review the right to, and process for changing services and/or service providers.	• DMRS Case Manager , ISC or Agency Case Manager
8. Review the Waiver Program and available waiver services	• DMRS Case Manager , ISC or Agency Case Manager
9. Review the person's rights under Title VI and complete the form in Appendix B2 entitled "Acknowledgement of Receipt of Title VI Notice". A description of Title VI is also included in Appendix B3 entitled "Discrimination is Prohibited".	• DMRS Case Manager , ISC or Agency Case Manager
10. Discuss the requirements for and importance of maintaining financial eligibility.	• DMRS Case Manager , ISC or Agency Case Manager
11. Review assessment results and any accompanying therapeutic plans of care or proposed behavior plans to ensure the results are consistent with the person's overall condition/situation and explain how the assessment results are relevant to the planning process.	• DMRS Case Manager , ISC or Agency Case Manager • Person, Family, Friends and Legal Representative
12. If appropriate, consult with those who completed the assessment(s) to interpret results, seek clarification or to ask about alternative recommendations for identifying needs.	• DMRS Case Manager , ISC or Agency Case Manager • Person, Family, Friends and Legal Representative
13. Identify any additional assessments or	• DMRS Case Manager , ISC or

What Happens	Who Is Responsible
evaluations that are needed and include the request for these evaluations along with the reason why these assessments are needed in the initial ISP. Use the "Possible Indicators for Therapeutic Service Assessments" included in Appendix C3 to assist in identifying therapeutic services that may be appropriate to address a health and safety need or to alleviate barriers to the person's outcomes.	Agency Case Manager • Person, Family, Friends and Legal Representative
14. Draft the "Personal Focus" part of the ISP following the guidelines set forth in Chapter Five.	• DMRS Case Manager , ISC or Agency Case Manager • Person, Family, Friends and Legal Representative
15. Draft as much of the "Action Plan" part of the ISP as possible following the guidelines set forth in Chapter Five.	• DMRS Case Manager , ISC or Agency Case Manager • Person, Family, Friends and Legal Representative
16. Identify the services and supports that will be necessary to meet the person's needs.	• DMRS Case Manager , ISC or Agency Case Manager • Person, Family, Friends and Legal Representative
17. If the person will need residential services, provide and discuss information about the various models available including the Family Model, Supported Living, Residential Habilitation, Semi-Independent Living and Personal Assistance using the forms included in Appendix B.	• DMRS Case Manager , ISC or Agency Case Manager
18. If the person will need Personal Assistance, determine the amount of service needed using the Personal Assistance Planning List in Appendix B9.	• DMRS Case Manager , ISC or Agency Case Manager
19. If the person will need day services/supports, discuss employment as the first option. If the person chooses employment, a vocational assessment should be requested. If the person does not want competitive employment, discuss all other day service options, including the option to have a vocational assessment completed.	• DMRS Case Manager , ISC or Agency Case Manager

What Happens	Who Is Responsible
20. Provide a list of available providers and information regarding the right to choose any willing, available provider. A list of current waiver providers can be obtained from the DMRS Regional Office.	• DMRS Case Manager , ISC or Agency Case Manager
21. Contact chosen providers and arrange start dates for services. If a provider cannot be located, the ISP can be submitted without a designated provider and all appeal processes should be accessed for a delay in services.	• DMRS Case Manager , ISC or Agency Case Manager
22. Complete the "Services and Supports" section of the initial ISP.	• DMRS Case Manager , ISC or Agency Case Manager
23. Prior to the effective date, submit the initial ISP to DMRS for approval and authorization of services as an "Urgent" request. * The initial ISP effective date is the date the plan is to be implemented. The effective date will be thirty (30) days from the date of enrollment listed on the DHS Form 2362 for Medicaid-eligible service recipients.	• DMRS Case Manager , ISC or Agency Case Manager
24. Review all rights and responsibilities including appeal rights, complaint resolution processes and the process for changing services, service levels and providers.	• DMRS Case Manager , ISC or Agency Case Manager
25. Monitor services as described in Chapter 9.	• DMRS Case Manager or ISC • Providers
26. Amend the ISP as assessment results become available and more information is learned about the person.	• DMRS Case Manager or ISC • Person, Family, Friends and Legal Representative

Other Important Things to Know:

- The initial ISP must include services necessary to ensure the person's health, safety and welfare. If little is known about the person, necessary supports must be put into place until such time as the person's needs are identified.
- It is optimal to have service providers involved in the development of the initial plan if at all possible. Often this is not possible due to the time constraints. It is critical that the plan be amended with appropriate support goals, risk planning and actions once providers are in place and able to participate in the planning process.
- The ISP must be an accurate reflection of the person's wants and needs. Any contradictory information should be resolved and accurately recorded in the ISP.
- The ISP is a reflection of what is important to the person within the framework of health and safety.
- Risk Issues that are not being planned for must be documented on the Risk Analysis and Planning Tool included in Appendix C2.
- If therapeutic services are needed but the physician's order is not available at the time the plan is finalized, the service cannot be requested. The need for the service(s) should be included in the personal focus section of the plan, but outcomes, actions and the actual request for the service should not be included. It is acceptable to discuss and plan for the services at the planning meeting and then include them in an amendment when the physician's order is obtained.
- Therapeutic services do not take the place of direct services. They do provide a mechanism for developing therapeutic based goals and actions, training of staff to implement those goals and actions and oversight to ensure they are effective.
- Behavior services focus on helping the person to reduce challenging behaviors and to develop alternative appropriate behaviors to be more successful in community life. This is accomplished by working in partnership with the staff of residential and day services, and parents, for those who live at home. Thus, outcomes, goals and actions are more likely to be achieved, if plans are developed with the persons who are going to implement the plans. Behavior services do not require physician's orders.
- If a provider cannot be located, services should be requested and the person should be assisted in filing a delay in service appeal.
- There must be at least one outcome, goal or action for each service requested with the exception of Independent Support Coordination, Transportation for Personal Assistance, Establishment and MR Housing.
- ISPs do not contain required or suggested staffing ratios. The plan should identify the person's needs, outcomes, goals and actions. Providers determine staffing patterns needed to ensure the person's needs are met and that the ISP is fully implemented.

Provider Manual References:

- Chapter 3 Individual Support Planning and Implementation

Resources:

- Residential Services Handbook
- Day Services Handbook
- Personal Assistance Resource Manual

Training:

- Independent Support Coordination
- ISP Overview

SECTION THREE
ASSESSMENTS
INTRODUCITON

Assessments are a process for identifying a person's capabilities and needs. Assessments are a critical part of the planning process because they provide valid information that can be used to make better decisions about what needs to happen to help the person lead a good quality of life and document the necessity for specific services. Most formal assessment tools help identify what is important for a person to live in the community within the framework of health and safety. Informal assessments do not require standardized formats, but include recognition and documentation of every day activities. It is also important to engage in person centered planning that identifies what is important to the person to have a quality life.

Assessments are not a single event, but rather an on-going continuous process of evaluating the effectiveness of services provided.

Formal assessments include the Inventory for Client and Agency Planning (ICAP), professional assessments (such at therapeutic, behavioral, physical, psychological, psychiatric, etc.) and risk assessment. Information from the family or conservator as well as the person being assessed is integrated into the assessment process. Informal assessments include observations of the person, interviews with the person and interviews with those who know the person well.

Assessment information and subsequent recommendations should be synthesized along with all other pertinent information about the person so that it can be considered in the planning process. The ISP should be reflective of assessment information and should clarify any discrepancies between assessment information and the plan for services. It is important to maintain the person centered aspect of this process. The person and legal representative have the final decision on what will be incorporated from the assessments into the final ISP.

Some of the ways that assessment information can be used in the planning process are to:

1. Identify skills the person can gain and ways the person can maintain, improve or slow regression of existing skills;
2. Initiate discussion about critical things that need to be maintained to help the person be happy, healthy, safe and secure in their home:
3. Identify risks in the person's life;
4. Identify things the person has difficulty doing or cannot do because of a lack of modifications, adaptations, equipment or supplies;
5. Identify barriers that might prevent the achievement of outcomes and goals or interfere with the management of risks;

6. Identify activities that might help in achieving outcomes or goals and manage identified risks and
7. Identifies the function or purpose of the behaviors presenting a barrier or danger. The function is important because, once identified, the team will be more aware of the person's motivation. The behavior analyst and the team can develop a plan to teach behaviors to replace the negative behaviors with more socially appropriate and effective behaviors.

SECTION THREE
ASSESSMENTS
INVENTORY FOR CLIENT AND AGENCY PLANNING (ICAP)

What: The ICAP results provide information concerning the skills that an individual has and those that the individual has yet to develop. Consideration should be given during planning to which skills would enable the person to function more independently, to improve the person's quality of life or that are necessary in order to achieve other outcomes. Outcomes for acquiring selected skills should be incorporated into the ISP for the providers of residential and/or day services to address. The strategy for acquisition for some skills may need to be coordinated with one or more clinicians. In those instances, the outcomes should indicate that multiple providers are responsible and will collaborate to assist the individual to achieve the outcome.

The ICAP provides information about the degree to which medical conditions limit the individual's participation in daily living activities as well as social activities and the amount of medical professional service the individual requires. It provides a description of any physical limitations the person has. And, it provides information about the type and severity of behavior problems the individual has. These indicators should be carefully considered when identifying the services being requested. For example, if an individual has "normal" or "marginal" behaviors, intensive behavior services are probably not justified.

Finally, the ICAP results are a part of DMRS' determination of the rate that providers receive for providing residential and day services. Please see Appendix E15 for additional information.

Who: Person, Family, Friends and Legal Representative
Residential Services Provider
Day Services Provider
Personal Assistance Provider
DMRS Case Manager (For individuals enrolled in the Self Determination Waiver & on the DMRS Waiting List)
Independent Support Coordinators (For those individuals who do not receive services from other providers.)
Dual Diagnosis Management (for Members of the Settlement Agreement and Remedial Order Classes)

When: ICAPs are completed for everyone as they are entering a DMRS HCBS Waiver Program. They will be completed every other year thereafter or more frequently if there is a significant change in the person's life.

Process: Responsibility for completion of the ICAP is as follows:

- DMRS Regional Office staff complete the initial ICAP for people just entering any DMRS HCBS Waiver program.
- Dual Diagnosis Management (DDM) completes all subsequent ICAPs at 2-year intervals.

What Happens	Who is Responsible
1. Meet with the person, legal representative, family and those who know the person well to ensure accurate information is obtained.	• Provider
2. Forward copies of required documents to the DDM assessor. These documents include a copy of the full DMRS cost plan summary, Health Passport, and additional documents establishing a formal diagnosis, functional ability and behavioral issues as relevant.	• Provider
3. Insure that the individual's personal record is available for review at the time and location of the interview.	• Provider
4. Assist DDM in gathering conservator/family contact information and with inviting conservator/family to have meaningful participation in the ICAP assessment if they so choose	• Provider
5. Send Score Summary Report to the ISC, DMRS Case Manager and Service Providers	• DDM
6. Review ICAP results with the person, legal conservator, family.	• ISC/ DMRS Case Manager • Provider (if state funded)
7. Use the ICAP information in the development of the plan as described in Section Five.	• Planning Team (as described in Section Five)

Other Important Things to Know:

- The ICAP can and should be completed as often as necessary to ensure that it accurately reflects the abilities and needs of the person.
- When completing the ICAP, information should be gathered from those who know the person well and have ongoing, daily contact with the person.
- The ICAP is a valuable tool for supporting the need for some services.
- Discrepancies between ICAP results and actual needs should be explained in the ISP. For example, a person may score low in regards to behavioral issues because current intensive supports are effective in managing them. However, if those supports were disrupted, it would be very detrimental to the person and his/her quality of life. In this situation, the need to continue the intensive supports, based on historical information and the negative effect that disruption of those services would have, should be well documented in the ISP.

Provider Manual References:

- Chapter 3 "Individual Support Planning and Implementation

Resources:

- ICAP Form (Included in Appendix C1)

Training Available:

- ICAP Training – Online

SECTION THREE
ASSESSMENTS
RISK ASSESSMENT

What: DMRS has a standardized Risk Issues Assessment Tool used to identify possible risk factors for the person and then use the information gathered to plan ways to address, manage or alleviate those risks while promoting personal growth, independence and respect for personal choices.

Who: Planning Team comprised of:
DMRS Case Manager (For Individuals Enrolled in the Self Determination Waiver)
Independent Support Coordinator (For Individuals Enrolled in the Arlington or Statewide Waiver)
Person, Family, Friends and Legal Representative
Providers

If there are specific members with unique responsibilities, they will be identified separately from the Planning Team.

When: The Risk Assessment should be completed as soon as possible after enrollment into services, at least ninety (90) calendar days prior to the ISP effective date and any other time there is a significant change in the person's life that may impact the risks for that person.

Process:

What Happens	Who is Responsible
1. Complete the "Risk Issues Identification Tool" included in Appendix C2. In Part I, identify all risks that you know or believe to apply for the person. Each service provider should cover all areas of known or suspected risk, not just their area of expertise. Briefly describe why the issue currently presents a particular risk to the person or how the issue has presented significant risk in the past.	• All providers who support the person, including the ISC
2. In Part II, summarize the number and type of DMRS reportable incidents and high risk reviews since the last annual planning process was completed.	• Primary provider (Residential provider if the person receives residential services, Day services provider if the person does not receive Residential Services, PA provider if the

	person receives only personal assistance or the DMRS Case Manager/ISC if the person receives neither Residential or Day Services.
3. Gather information from the person, legal representative and family to ensure all risks have been identified.	• DMRS Case Manager or ISC
4. Compile all risk factors into one document.	• DMRS Case Manager or ISC
5. Review risk assessments to determine if there are circumstances, conditions, locations or times of the day when risk appears to be increasing and/or early warning signs that may be related to risk such as specific actions or communications. Contact providers for any clarifications if needed.	• DMRS Case Manager or ISC
6. Review risk assessment information with the person, legal representative and family as part of the pre-planning process described in Section Four. Make sure all risks have been identified and discuss any disagreements about risk factors.	• DMRS Case Manager or ISC
7. Use the risk assessment information in the planning process as described in Sections Two and Five.	• Planning Team
8. Submit a new risk assessment anytime there is a change in risk issues for the person.	• All providers
9. Notify the DMRS Case Manager or ISC anytime you have concerns that risk issues are not being managed.	• Person, Family, Friends and Legal Representatives • All Providers

Other Important Things to Know:

- Identification of risks and planning to manage them is essential to ensure the person's health, safety and welfare.
- It is everyone's responsibility to report to the DMRS Case Manager or ISC when plans for managing risks are not working or risk factors change.
- A Risk Assessment must be done for all services the person receives. If the person receives multiple services through the same agency, one (1) tool may be completed which covers all services or an individual tool may be completed for each service.

Provider Manual References:

- Chapter 3 "Individual Support Planning and Implementation

Resources:

- Risk Issues Identification Tool

Training Available:

- Risk Assessment

SECTION THREE
ASSESSMENTS
THERAPEUTIC SERVICE ASSESSMENTS

What: Therapeutic service assessments include occupational therapy, physical therapy, speech language pathology, audiology, nutrition, and orientation and mobility assessments. Therapeutic service assessments are indicated when an individual is experiencing a barrier to accomplishing outcomes and actions or has health and safety needs. The purpose of a clinical assessment is to determine if there is a need for therapeutic supports and services to assist an individual to accomplish outcomes and actions throughout their day to day life.

Who:

Occupational Therapists
Physical Therapists
Speech Language Pathologists
Audiologists
Nutritionists
Orientation and Mobility Specialists

When: Therapeutic service assessments are provided prior to the provision of any therapeutic services and supports in order to establish/justify a need for a particular service. If therapeutic services are already in place, an annual reassessment and updated therapeutic plan of care must be completed and provided to the ISC/CM no later than 90 days prior to the ISP effective date.

Process: The Individual Support Plan must justify the need for an assessment. Referrals for an assessment must be specific. General reasons for referral for an assessment such as "OT to assess leisure skills", "PT to assess mobility", or "SLP assessment for mealtime" are not acceptable. The reason for a referral must indicate the specific issue(s) the individual is having that affects his/her function such as, "OT to assess for adaptations needed in order for Sally to participate in gardening and home management tasks due to limited use of her hands and arms", "PT to assess Bobby's ability to walk with a walker so that he can get around his home without using his wheelchair", or "SLP to assess Joe at mealtime due to frequent coughing during meals and a recent choking incident".

Assessments must incorporate the input of the individual and those who know the individual best, as appropriate, such as direct support professionals, family, legal representatives, and independent support coordinators or DMRS Case Managers. Assessments may identify other issues or functional potentials that result in recommendations in addition to issues addressed in the reason for referral. The comprehensive analysis portion of the assessment must identify, using clear, simple,

and concise language, how individual limitations impact function in order to justify the need for any recommended services. Assessment recommendations should identify interventions needed to support the person in various environments as relevant. A therapeutic plan of care (POC) is then drafted to include recommended goals, interventions, and timeframes for completion. The initial assessment and the therapeutic POC are forwarded to the ISC/CM upon completion or within 30 days from the date the assessment was authorized to occur or at least 90 days prior to the ISP effective date for annual reassessments. During the pre-planning and planning meeting process, the individual and/or his/her legal representative will determine which recommendations will be acted upon.

Other Important Things to Know:

- Physician's orders are required in order for DMRS to authorize funding for all therapeutic service assessments
- Separate physician's orders are required for assessment and services. "Assess and Treat" orders cannot be accepted.
- The assessment must be legible in order to be reviewed

Provider Manual References:

- Chapter 3, Section 3.7
- Chapter 13, Section 13.8, 13.9, 13.10, 13.11, 13.12, (and corresponding sections in Chapters 14 for orientation and mobility and Chapter 15 for nutrition)

Resources:

- Possible Indicators for Therapeutic Service Assessments (Included in Appendix C3)
- Sample Therapeutic POC form (Included in Appendix C4)
- Technical Assistance Manual for Therapeutic Services

Training Available:

- Training is available through the Regional Therapeutic Services Teams on how to identify the need for a therapeutic service assessment.
- Training is available through the Regional Therapeutic Services Teams for clinicians on the process of providing quality assessments and analysis of needs, documenting the analysis of needs identified, and constructing functional and measurable goals and interventions for individuals with mental retardation and developmental disabilities.

SECTION THREE
ASSESSMENTS
BEHAVIOR ASSESSMENT

What: A behavior assessment is requested when the person is regularly presenting behaviors that present a health or safety risk to the person or others or the behaviors are interfering with or preventing participation in home or community activities. The request should contain as much information as possible about the behavior including what the presenting behaviors are and how they are interfering with the person's plan of care, the environments in the behaviors have been observed, how intense or dangerous the behaviors have been, and any data available.

- The initial behavior assessment is completed by a behavior analyst upon receipt of a request for behavior services.

The behavior assessment includes the following information

1. The reason for referral, including a description of the target behaviors that are dangerous or presenting a barrier to successful completion of the outcomes/actions identified in the ISP.

2. The level of need, if any, for behavior services. Given the information available, the behavior analyst makes a determination that the behavior may be treated or influenced by a clinical behavioral intervention and thus a behavior service is recommended.

   Some behaviors may not be clearly indicative of clinical treatment through behavioral intervention and the behavior analyst may recommend additional assessments by other clinical disciplines. These additional clinical disciplines may assess the behavior using their treatment approaches, and may suggest an alternative treatment approach for the behavior.

   In some cases, a behavior may be reviewed in the assessment that was a listed as a concern in the referral, but may be managed by simple adjustments in the environment. The assessment may suggest risk management adjustments to be noted in the ISP or suggest ideas for environmental adjustments that do not require a behavior support plan.
3. If there is a determination of a behavior need that may be responsive to a clinical behavioral intervention, the likely function, purpose and influences on the behavior are to be documented

Information used to determine the conclusions about behavior need and the function of the behavior includes interviewing and spending time with the person to understand the person, along with interviewing the direct support professional and others, and observing their interactions with the individual. The behavior analyst may train staff to collect specific behavioral data that will give information about the conditions under which the behaviors take place.
The behavior analyst will review these data and any other relevant records and report the findings in the assessment.

4. The assessment provides recommendations regarding the presenting behavior. Different recommendations may be given based upon the history and pattern of the behavior. Examples of recommendations are:
   Implement clinical behavior change interventions a proposed behavior support plan;
   Implement behavior maintenance interventions in a proposed behavior maintenance plan;
   Behavior services are not needed and suggestions for local supports on how to respond are provided;
   The behavior does not suggest behavior services, but other discipline assessments might be considered.

5. If recommended, details are provided on the proposed behavior services.

   This is where the behavior analyst will describe the interventions proposed for the behavior support plan or the behavior maintenance plan. These interventions need to be discussed by the individual, legal representative and the planning team so that the interventions are the least restrictive, but likely effective interventions that can be carried out by the community agencies. The group also needs to discuss how the behavior plan integrates with other services. The behavior plan should be discussed in as near as possible to its finished form. This is important because it will allow the community agencies to see a draft so they can participate in discussions about the feasibility of carrying out the plan.

6. Additional details that are provided in the behavior assessment are: the amount of behavior services proposed and the justification for these services, goals and objectives for the service and a description of any behavior specialist services if applicable.

An annual service review or reassessment is completed if behavior services have been in place and discharge has not occurred prior to the annual ISP effective date. This service review or reassessment is completed prior to the annual ISP and is used to summarize progress and to recommend what, if any, behavior services are proposed for the new ISP year. The annual service review or reassessment is provided to the ISC/CM no later

than 90 days prior to the ISP effective date. The annual service review or reassessment may be incorporated into an expanded Clinical Service Monthly Review.

- The annual service evaluation or reassessment contains the following information:

1. The progress to date, including a summary of the changes that have occurred due to the application of behavior interventions, as shown on graphs of the behaviors;
2. The recommendations on what, if any, behavior services are proposed for the next year, justification for these services, and any significant proposed changes in the behavior plan to be considered.

All assessments should be written in clear and practical language so that the information can be used by all the team members in considering the most beneficial way to help the person achieve their outcomes and goals.

Who: Behavior Analyst.

Copies of the behavior assessment are sent to the Independent Support Coordinator/DMRS Case Manager (ISC/CM), other members of the Planning Team as appropriate, and the Regional Office Director of Behavior Services.

When: The assessment must be completed within 30 calendar days of the service authorization for newly enrolled individuals. If behavior services are ongoing, an annual service evaluation or reassessment, including recommended plan revisions, must be submitted to the ISC/CM no later than 90 days prior to the ISP effective date.

Process
For Newly Enrolled or
For Persons Enrolled and Now May Need Behavior Services

What Needs to Be Done	• Who Does It
1. Meet with the Circle of Support to discuss outcomes and needs	• ISC or DMRS Case Manager
2. Complete referral for assessment	• ISC or DMRS Case Manager
3. Authorize service hours	• Regional Office
4. Take receipt of authorized hours and begin assessment	• Behavior Analyst
5. Complete assessment and send copies to the ISC/CM, Regional	• Behavior Analyst

Office Behavior Analyst, and appropriate Planning Team members	

Process

Person Receiving Ongoing Behavior Services

What Needs to Be Done	Who Does It
1. Complete annual service evaluation or reassessment and send copies to the ISC/CM, Regional Office Behavior Analyst, and appropriate Planning Team members no later than 90 days prior to the ISP effective date	• Behavior Analyst

Other Important Things to Know

- The annual service evaluation or reassessment may be integrated or attached to the Clinical Service Monthly Review completed 90 days prior to the ISP effective date.

Provider Manual References

- Chapter 12: Behavior Health

Resources

- Behavior Issues Tip Sheet (Included in Appendix C5)

Training or Technical Assistance

- There are no regularly scheduled training sessions, but training and technical assistance is available from the Regional Office Behavior Analyst Director. The information is also included in new behavior provider orientation.

SECTION THREE
ASSESSMENTS
HEALTHCARE OVERSIGHT FORM

What: The HealthCare Oversight Form provides information necessary to understand both medical issues and functional abilities to support health, quality of life and maximal functioning in everyday life. The components of these areas impact every aspect of a person's life. While not an assessment, it is critical to consider when evaluating assessment, health, risk and other information about the person. The HealthCare Oversight Form consists of a three page outline of health information and functional abilities and a record of health encounters of the prior year since the last ISP.

This includes:

- Accurate diagnoses
- Current medications
- Health encounters in areas of prevention, acute illness, chronic medical problems & medical issues relevant to developmental diagnoses
- Dental Issues
- Physical Status Review (also titled the Health Risk Screening Tool)
- Legal Healthcare Issues
- Functional abilities
- Immunizations
- Special Needs
- Primary Care Physician/ Specialist Information
- Medical History for the last year
- Behavior Issues
- Significant Laboratory/ Test Findings
- List of other available Clinical Data
- Questions

This information should be in agency charts referring to healthcare encounters of the prior year. Reviewing the information does not require it be done by a healthcare professional. The person filling out the form needs to be familiar with the person, the agency charts and the ISP.

Who: Residential Provider, if a person is in a residential setting
Day Services Provider, if the person is only in a day program
Personal Assistance Provider, if receiving only personal assistance
Person, Family, Friends and Legal Conservator if the person receives services other than residential or day
Registered Nurse if the person is receiving Level 4 services

The HealthCare Oversight Form does not need to be completed by healthcare professionals as it is an extraction of information collected from the prior year of an individual's healthcare encounters. Ideally, the person completing the form should be familiar with the person, the agency charts and some issues of concern that might need to be discussed during the ISP process.

When: The HealthCare Oversight Form is to be completed prior to the planning meeting so that it can be reviewed with the person and legal representative during pre-planning. However, it is a document that could be kept current over the course of the year so that most information would already be in place by the time it is due.

Process: **All activities in this section are performed by the entity responsible as described above unless otherwise noted.**

What	Who
1. Review of entire record of diagnoses, healthcare encounters, laboratory results etc. of the prior year to be found in the agency charts	• As stated above.
2. If information is unavailable or has not been kept in a useful manner, technical assistance should be sought from the Regional Office.	• As stated above.
3. Missing information: In many cases, accurate information may not be available. In these situations, this needs to be corrected which might result in a request for technical assistance from Regional Nurses.	• As stated above.
3.a. Accurate diagnoses	• As stated above
3.b. Medication: Each medication should have a corresponding diagnosis. Questions about diagnoses and treatment should be discussed with the Primary Care Physician.	• As stated above...
3.c. Dental: This should address status needs and a reference to needs for anesthesia for procedures. Any questions or concerns should be discussed with the dentist.	• As stated above.
3.d. PSR Score: This does not need to be completed by a nurse unless the person receives Level 4 services.	• As stated above.
3.e. Legal Healthcare Issues: This area addresses the presence and or need of a conservator. It also addresses Do Not Resuscitate and end of life issues.	• As stated above.
3.f. Functional Abilities: This section should be self-explanatory.	• As stated above.

3.g. Immunization: This is self-explanatory and should come from records. Immunization records are often unavailable in adults and attempts should be made to keep these current as to avoid unnecessary repeat immunizations and to keep things up to date. Questions or concerns should be discussed with the Primary Care Physician.	• As stated above.
3.h. Special Needs: This is self-explanatory but bears much discussion.	• As stated above.
3.i. PCP/ Specialist Information: This refers to the current professional that the individual is seeing. If the individual changes from one PCP to another during the year, it should be kept in mind that the medical records need to be transferred. This can only be done by the request of the individual who is the patient.	• As stated above.
3.j. Medical History of Prior Year: This is extracted from the agency chart showing medical encounters and it should be a concise review of all hospitalizations, ER visits and illness' requiring physician intervention.	• As stated above.
3.k. Behavior Issues: This should address whether or not the person has supports in this area or if there are concerns.	• As stated above.
3.l. Significant Laboratory/ Test Findings: This refers to testing which is either significant or requires follow-up and it might be overlooked if not reviewed.	• As stated above.
3.m. List of Available Data: This area covers types of data that are often collected on individuals. This is an opportunity to both review the data and discuss whether or not the data needs to be kept or whether new data needs to be collected.	• As stated above.
3.n. Questions: This is an area where persons who may have questions about diagnoses, treatment or prognosis could be discussed. It is also an area to make sure that medication side-effects have been discussed as well as issues of sexuality.	• As stated above.
4. Information contained in the Health Care Oversight Form should be discussed during pre-	• Person, Family, Friends and Legal Conservator

planning activities as described in Section Four.	• ISC or DMRS Case Manager
5. Planning regarding health care issues identified on the Health Care Oversight Form should be integrated into the ISP and discussed at the planning meeting as described in Section Five.	• Person, Family, Friends and Legal Conservator • ISC or DMRS Case Manager

Other Important Things to Know:

The HealthCare Oversight Form is an outline for discussion during pre-planning so that functional health issues can be integrated into other areas of the person's life and included in the ISP during the Planning Meeting. This also provides an outline for individuals to be clear about diagnoses, treatment and prognosis as well as the possibility of progression and complications. Consideration of healthcare issues should be integrated into discussions of other parts of life. As an example, an individual with diabetes probably would not do well with a supported employment position in a candy factory or an individual with physical limitations might need adjustments but could do a job initially thought not to be appropriate. The primary use of this form provides a framework for discussion to promote quality of life, well-being and maximizing functional abilities in community participation. The Healthcare Oversight Form can be completed by anyone who knows the person well and does not require prior training before completion. The responsibility for completion would be as follows, residential, day/personal assistance if not receiving residential.

The PSR or Physical Status Review is also known as the HRST or Health Risk Screening Tool and is used to provide the provider/support team with guidance in determining the person's need for further assessment and evaluation to address identified health risks. It will also guide the team in determining the need for professional services. General and individual specific staff training is identified to address health risks and provide a foundation for health care management. It includes 22 rating areas, review recommendations and notes, evaluations and service requirements and staff training requirements based on rating results. Finally, computation of category scores and identification of a health care level are computed on the face sheet. All persons completing or reviewing the PSR tool must receive training prior to its completion.

The Health Passport is another area covered under Health Care Management and Oversight. This is a document that provides a description of health-related information that represents the service recipient's health history and current health status. It is also inclusive of emergency contact information. The Health Passport is intended to be kept with the person at all times. It may be carried by the person or by direct support staff if the person chooses not to carry it. The Health Passport is completed by the residential provider. If the person does not receive residential services, then it would be completed by either the day provider or the personal assistance provider. If the person does not receive any of these mentioned services, it would be presented by the ISC.

Provider Manual References:

- Chapter 11, Health Management and Oversight

Resources:

- HealthCare Oversight Form (Included in Appendix C6)
- Instructions for completing HealthCare Oversight Form (Included in Appendix C7)

Training Available:

- Regional Nurses provide training both individually and in group.

SECTION THREE
ASSESSMENTS
VOCATIONAL ASSESSMENTS

What: Vocational assessments are used to determine a person's strengths and needs and/or explore a person's interests, skills and talents as they relate to employment and other vocational activities. Assessments are also used to help service recipients become aware of available employment options and to help determine the best employment alternatives to meet individual needs. In support of the Employment First Initiative, DMRS advocates that employment be considered in planning for day services. Employment should be reconsidered, at a minimum, during the annual ISP update and vocational evaluations be completed every three years.

Who: Person, Family and Friends
DMRS Case Manager
Independent Support Coordinator
Division of Rehabilitation Services Counselor
Day/Employment Providers

When: A vocational assessment may be performed any time it is needed, but is required at least every (3) three years, unless the person is already employed or if the person does not wish to seek employment and declines the assessment.

If the person has expressed interest in pursuing employment-based options, a vocational assessment should be completed and submitted to the Independent Support Coordinator or Case Manager at least ninety (90) calendar days prior to the person's Individual Support Plan meeting.

Process:

What	Who
1. At least ninety (90) days prior to the ISP meeting, a vocational assessment will be completed. Vocational assessments are performed by either employment-based day service providers that contract with the Division of Mental Retardation Services or the Department of Human Services, Division of Rehabilitation Services (DRS) when DRS has an open case and the DRS counselor agrees that an assessment needs to be completed.	• DRS Counselor • Day Services Provider
2. The information obtained from the assessment is discussed as a part of pre-planning activities as described in Section Four.	• Person, Family, Friends and Legal Representative • ISC or DMRS Case Manager

3. Vocational assessment information is used to develop the Individual Support Plan as described in Section Five.	• Person, Family, Friends and Legal Representative • ISC or DMRS Case Manager

Other Important Things to Know:

DMRS Vocational assessments are required every three years unless the person is already employed or unless the person does not wish to seek employment and declines the assessment. Appendix C contains the following tools and resources to assist in the exploration of work:

- The DMRS Vocational Evaluation which includes two sections; the Basic Information form and the Job Site Assessment.
- The Discovery Process: This document assists providers in structuring time in community-based day to assist someone to explore if they want to work, and if so, what type of work they are interested in.

Provider Manual References:

- Chapter 10 Day Services

Resources:

- Day Services Handbook
- DMRS Vocational Assessment Instructions (Included in Appendix C8)
- Vocational Assessment Basic Information Form (Included in Appendix C9)
- Vocational Assessment Supplemental Evaluation/ Job Site Assessment (Included in Appendix C10)
- The Discovery Process (Included in Appendix C 11)

Training Available:

- Regional Day Service Coordinators provide training upon request.

SECTION FOUR
PRE-PLANNING ACTIVITIES

What: Pre-planning activities are a series of activities to assist in the development of the Individual Support Plan (ISP). These activities may occur by telephone, during face to face visits with the person and his/her family, during monitoring visits, etc. and may occur over a period of time.

Who: DMRS Case Manager (For individuals enrolled in the Self Determination Waiver)
Independent Support Coordinator (For individuals enrolled in the Arlington or Statewide Waiver)

Agency Case Managers (For individuals receiving State Funded services only)
Person, Family, Friends and Legal Representative
Behavior Service Providers
Therapeutic Service Providers
Direct Service Providers

When: Prior to updating the annual ISP, typically 90-120 days prior to the effective date of the ISP.

Process:

What Happens	Who Is Responsible
1. Gather all available assessment and evaluation information including the original plan of care, physical, psychological evaluation, ICAP, risk assessment, historical information, etc.	• DMRS Case Manager, ISC, or Agency Case Manager
2. Talk with the person to learn what is important to him/her in order to have a quality life.	• DMRS Case Manager, ISC, or Agency Case Manager
3. Talk with the legal representative, family, friends, and others who know and care about the person to learn what they feel is important for the person.	• DMRS Case Manager, ISC, or Agency Case Manager
4. Explain the ISP and its purpose to the person, legal representative and family. j. The ISP and the planning process is person centered and should include what is important to the person as well as include what others feel the person needs.	• DMRS Case Manager, ISC, or Agency Case Manager

k. The ISP is the document that describes what the person's life is like, what they want it to be like, what they need to be healthy and safe, how all of that is going to happen and who is going to do it. l. Ensures the person is assisted in achieving a full life as a member of his/her community in ways that he/she prefers. m. It is the way everyone who knows and cares about the person and supports them stays accountable for what needs to be done. n. It includes planning and development of actions to maintain what is working. o. It looks at what is absent in the person's life to ensure they have what is important to them within the framework of health and safety, what needs to change and how to promote the needed/desired changes. p. It is a document that is required by federal regulation and supports the need for state and federal funding to pay for the services the person needs. q. It is reviewed by DMRS to ensure that it meets all applicable requirements and for authorization of services. r. Monitoring the ISP ensures that progress is made toward achieving the person's outcomes.	
3. Explain the planning process to the person, legal representative and family. a. The planning process begins with assessment of the person's skill, abilities and needs or re-assessment to determine progress in meeting previous outcomes, goals or actions. b. Pre-planning activities are designed to give the person, legal representative and family information about services and their rights as well as the opportunity to discuss what they want to have happen and any concerns they might have outside the presence of paid providers. It includes identification of personal outcomes, supports for daily life and risks.	• DMRS Case Manager, ISC, or Agency Case Manager

c. Meeting with those who know and care about the person and support them to determine how their outcomes will be met, to identify goals for supports for daily life, how those will be met, planning for risk issues and identifying the services and supports needed to make the plan happen. d. Implementation of the ISP. e. Monitoring implementation. f. Amendments when needed.	
i. Review the person's rights and responsibilities, including appeal rights and complaint resolution procedures. A compilation of individual rights from Chapter 2 of the DMRS provider manual is included in Appendix B1.	• DMRS Case Manager, ISC, or Agency Case Manager
i. Review the right to, and process for changing services and/or service providers.	• DMRS Case Manager, ISC, or Agency Case Manager
1. Review Freedom of Choice and complete the form. If the person chooses ICF/MR services, provide them with a list of available providers and assist them in contacting and visiting with these providers as requested. A listing of available ICF/MR providers is available from the DMRS Regional Office.	• DMRS Case Manager, ISC, or Agency Case Manager
8. Review the Waiver Program and Available Waiver Services	• DMRS Case Manager, ISC, or Agency Case Manager
9. Review the person's rights under Title VI and complete the form in Appendix B2 entitled "Acknowledgement of Receipt of Title VI Notice". A description of Title VI is also included in Appendix B3 entitled "Discrimination is Prohibited".	• DMRS Case Manager, ISC, or Agency Case Manager
10. Discuss the requirements for and importance of maintaining financial eligibility.	• DMRS Case Manager, ISC, or Agency Case Manager
11. Review assessment results and any accompanying therapeutic plans of care or proposed behavior plans to ensure the results are consistent with the person's overall condition/situation and explain how the assessment results are relevant to the planning	• DMRS Case Manager, ISC or Agency Case Manager • Person, Family, Friends and Legal Representative

process.	
12. If appropriate, consult with those who completed the assessment(s) to interpret results, seek clarification or to ask about alternative recommendations for identifying needs.	• DMRS Case Manager, ISC or Agency Case Manager • Person, Family, Friends and Legal Representative
13. Review the previous year's ISP. Specifically discuss: a. What worked well; b. What didn't work; c. What things need to change in the next year; d. What things should stay the same; e. Whether outcomes were reached and why or why not; f. The appropriateness and effectiveness of services and supports in meeting the persons needs and in completing/achieving outcomes, actions, support goals, etc.; g. The effectiveness of providers in completing/achieving outcomes, support goals, actions, etc.; h. Success in addressing, managing, alleviating or minimizing risk issues; i. Success in ensuring the person's safety, health and welfare; j. Identify ways the person has become more independent; and k. Identify ways in which the person has become more involved in the community. **Note: These items will be reviewed again at the ISP meeting. If the person, legal representative and/or family agree, they can be covered at the planning meeting only and not also as a part of pre-planning activities.**	• DMRS Case Manager , ISC or Agency Case Manager • Person, Family, Friends and Legal Representative
14. Review information gathered from service providers through formal monitoring or informal discussions this includes any monthly reviews, applicable staff notes, incident reports, documentation of progress on outcomes/actions, clinical provider notes, etc.	• DMRS Case Manager , ISC or Agency Case Manager • Person, Family, Friends and Legal Representative
15. Complete risk assessment tool and submit to the ISC/Case Manager at least 90 days prior to the ISP effective date	• DMRS Case Manager , ISC or Agency Case Manager • Service Providers

16. Discuss the person's satisfaction with services, supports and service providers.	• DMRS Case Manager , ISC or Agency Case Manager • Person, Family, Friends and Legal Representative
17. Determine the need for changes in the types of services, service models or level of service. If a change is needed, refer to the tools in Section Two.	• DMRS Case Manager , ISC or Agency Case Manager • Person, Family, Friends and Legal Representative
18. Determine if provider changes are desired and if so, provide appropriate choices and facilitate accessing the preferred provider(s).	• DMRS Case Manager , ISC or Agency Case Manager • Person, Family, Friends and Legal Representative
19. Update the "Personal Focus" part of the ISP following the guidelines set forth in Section Five. There are "Tip Sheets" in Appendix E that provide guidance about what should be included in each section of the Personal Focus part of the ISP.	• DMRS Case Manager , ISC or Agency Case Manager • Person, Family, Friends and Legal Representative
20. Update as much of the "Action Plan" part of the ISP as possible following the guidelines set forth in Section Five. There are "Tip Sheets" in Appendix E that provide guidance about what should be included in each section of the Personal Focus part of the ISP.	• DMRS Case Manager , ISC or Agency Case Manager • Person, Family, Friends and Legal Representative
21. Identify the services and supports that will be necessary to meet the person's needs.	• DMRS Case Manager , ISC or Agency Case Manager • Person • Conservator or Legal Representative • Family and Friends • Others Who Know and Care About the Person Invited to Participate
22. Identify any additional assessments or evaluations that are needed to address barriers to achieving the person's outcomes or to address health and safety needs. Use the "Possible Indicators for Therapeutic Service Assessments" in Appendix C3 to identify therapeutic services	• DMRS Case Manager , ISC or Agency Case Manager • Person • Conservator or Legal Representative • Family and Friends

that may be appropriate to address health and safety needs or alleviate a barrier to the person's outcomes.	• Others Who Know and Care About the Person Invited to Participate
23. Complete the "Services and Supports" section of the ISP. If a provider cannot be located, the ISP can be completed and submitted without a designated provider and all appeal processes should be accessed for a delay in services. See Section Five for more information about completing this section. See Appendix E for the Rates Tip Sheet	• DMRS Case Manager , ISC or Agency Case Manager
24. Determine the date, location and attendees for the planning meeting. All providers involved in supporting the person should be invited to the planning meeting.	• DMRS Case Manager , ISC or Agency Case Manager • Person, Family, Friends and Legal Representative
25. Distribute a draft of the ISP to all attendees prior to the planning meeting. The draft ISP serves as the invitation to the meeting and as notice to providers that the services they provide have been requested to be initiated or considered for continuation. The draft should be distributed as far in advance as possible.	• DMRS Case Manager , ISC or Agency Case Manager
26. Review the draft ISP prior to the planning meeting and be prepared to discuss the following at the planning meeting: a. Inaccurate, conflicting or missing information; b. Identify barriers that may inhibit or prevent the completion of outcomes/actions c. Identify outcomes and actions to alleviate those barriers and assist the person in achieving outcomes; d. Support goals needed to ensure the person's health, safety and welfare; e. Actions needed to ensure support goals are met; f. Risk factors not identified in the plan and mechanisms for addressing, managing, minimizing or alleviating those risks; g. Any other information needed to ensure completion of an executable ISP that accurately reflects the person's needs and preferences; and	• Direct Service Providers • Therapeutic Service Providers • Behavior Service Providers • Individual, Legal Representative and Circle of Support

h. Any recommended behavior interventions as described in the assessment of the draft of "What I Do to Carry Out This Plan". Refer to the ISP Meeting Preparation Checklist in Appendix D for guidance in reviewing the Draft ISP.	
27. Prepare to attend the planning meeting including all pertinent information and suggestions for finalizing the ISP. Refer to the ISP Meeting Preparation Checklist for guidance in preparing for the meeting.	• Direct Service Providers • Therapists • Behavior Service Providers • Individual, Legal Representative and Circle of Support

Provider Manual References

- Chapter 2 "Consumer Rights and Responsibilities"
- Chapter 3 "Individual Support Planning and Implementation"

Resources

- ISC & CM Documentation Forms "Annual ISP Review and Update Preparation" Sample (Included in Appendix G & H)
- Technical Assistance Manual for Therapeutic Services
- Technical Assistance Manual for Behavior Service Providers
- Day Services Handbook
- Residential Services Handbook
- Personal Assistance Resource Manual
- ISP Meeting Preparation Checklist (Included in Appendix D)

Training

- ISP Overview
- ISC Training
- The Regional Therapeutic Services and Behavior service Teams are available for technical assistance if there are questions or concerns about the quality of an assessment.

SECTION FIVE
ANNUAL INDIVIDUAL SUPPORT PLANNING

What: The Individual Support Plan (ISP) is an individualized, comprehensive description of the person as well as guidance for achieving unique outcomes that are important to the person in achieving a good quality of life in the community. It is the foundation for all service provision.

Who: Planning Team comprised of:
DMRS Case Manager (For Individuals Enrolled in the Self Determination Waiver)
Independent Support Coordinator (For Individuals Enrolled in the Arlington or Statewide Waiver)
Agency Case Manager (For Individuals receiving state funded services only)
Person
Conservator or other Legal Representative
Family Members
Others Who Know and Care about the Person
Providers

If there are specific members with unique responsibilities, they will be identified separately from the Planning Team

When: The effective date of an updated (annual) ISP can be no more than one calendar year from the effective date of the previous plan. Annual planning to update the plan must occur enough in advance to ensure that the plan can be finalized, submitted for review to DMRS at least 21 days prior to implementation and distributed to all involved providers prior to the effective date.

Process:

A. Prior to the Meeting

What Happens	Who Is Responsible
1. Review the draft ISP in detail and note any discrepancies/concerns.	• Planning Team
2. Be prepared to summarize progress toward each outcome and action for which the provider is responsible for in the current ISP.	• Planning Team
3. Be prepared to discuss any barriers to achieving outcomes or actions if they were not accomplished.	• Planning Team
4. Be prepared to discuss outcomes or actions that need modified and any additional ones that are	• Planning Team

needed.	
5. Be prepared to discuss Supports for Daily Life and Support goals that need to be implemented to ensure or address health and safety needs and risk issues	• Planning Team
6. Be prepared to discuss the person's daily schedule and how services will need to be coordinated to ensure they are provided in the most effective way.	• Planning Team

B. Meeting Management

What Happens	Who Is Responsible
1. Prepare an agenda to ensure everything is discussed.	• DMRS Case Manager , ISC or Agency Case Manager
2. Arrive at the location of the meeting ahead of time and prepare the meeting space.	• DMRS Case Manager , ISC or Agency Case Manager
3. Ensure that the seating and temperature are comfortable and conducive to conversation.	• DMRS Case Manager , ISC or Agency Case Manager
4. Assist the person in setting up refreshments if desired.	• DMRS Case Manager , ISC or Agency Case Manager
5. Set up any flip charts, make sure markers are available, etc.	• DMRS Case Manager , ISC or Agency Case Manager
6. Bring a copy of the draft ISP, assessment information and other pertinent information for review and reference.	• DMRS Case Manager , ISC or Agency Case Manager
7. Choose a facilitator. The facilitator is responsible for ensuring the person is at the center of the planning process, that everyone is heard and that any discrepancies or disagreements are resolved.	• Person • Person's Legal Representative
8. Have everyone introduce themselves.	• DMRS Case Manager , ISC or Agency Case Manager
9. Explain the purpose of the meeting and review the agenda.	• DMRS Case Manager , ISC or Agency Case Manager
10. Document what is decided at the meeting. Recording on flip chart paper is one way to ensure everyone can see what is discussed and serves as a record of the meeting. The Risk Analysis and Planning Tool must be completed.	• DMRS Case Manager , ISC or Agency Case Manager

Process:

C. Reviewing Existing Information At the Planning Meeting

Note: All activities in this section are performed by all members of the Planning Team.

What Happens
1. Review the previous year's ISP. Specifically discuss: a. What worked well; b. What didn't work; c. What things need to change in the next year; d. What things should stay the same; e. Whether outcomes were reached and why or why not; f. The appropriateness and effectiveness of services and supports in meeting the persons needs and in completing/achieving actions, outcomes, support goals, etc.; g. The effectiveness of providers in completing/achieving outcomes, support goals, actions, etc.; h. Success in addressing, managing, alleviating or minimizing risk issues; i. Success in ensuring the person's safety, health and welfare; j. Identify ways the person has become more independent; and k. Identify ways in which the person has become more involved in the community.
2. Review assessment results and any accompanying therapeutic plans of care or recommended behavior plans to ensure the results are consistent with the person's overall condition/situation and explain how the assessment results are relevant to the planning process. The person and/or legal representative makes the final decision about which recommendations will be incorporated for implementation.
3. Review information gathered from service providers through formal monitoring or informal discussions this includes any monthly reviews, applicable staff notes, incident reports, documentation of progress on outcomes/actions, therapeutic provider notes, Clinical Service Monthly Reviews, etc.
4. Discuss what risks have been identified and if planning will occur for them. The Risk Analysis and Planning Tool is a compilation of the Risk Issues Identification Tool completed by all providers of service during pre-planning and the decisions made on addressing each identified risk. If risk issues will not be addressed in the action plan, make sure this is documented on the "Risk Analysis and Planning Tool Form". This can be found in Appendix C2.

Process:

D. Develop the Plan

Note: All activities in this section are performed by all members of the Planning Team.

What Happens
1. Review the Face Sheet of the ISP and make sure that all information is correct.
2. Review the "Personal Focus" section of the draft ISP and update it. The "Personal Focus" section reflects the person's current life and what the person, his/her family

and legal representative, want his/her life to be like. This may include continuing existing supports so that some things don't change and/or changing existing supports so that some things do change. Make sure there is no conflicting information, that it accurately reflects the person and that it is complete. There are "Tip Sheets" in Appendix E that provide guidance about what should be included in each section of the Personal Focus part of the ISP.
2. Review the person's Personal Outcomes as well as any barriers or risk that may interfere with or prevent the outcome being accomplished. Remind the Planning Team that Personal Outcomes are what the person wants to learn, do or have happen in his/her life.
3. Identify any additional Personal Outcomes that others are aware of not included in the draft. Identify barriers or risks that may interfere with or prevent the outcome being accomplished. Refer to the Personal Outcomes and Supports for Daily Life Tip Sheet in Appendix E for a description of Personal Outcomes and guidance in identifying Personal Outcomes.
4. Review goals for Supports for Daily Life included in the draft ISP. Remind the Planning Team that goals for Supports for Daily Life are things that others think should happen for the person.
5. Identify additional goals for Supports for Daily Life as well as barriers or risks that may interfere with or prevent the goals from being accomplished not already included in the draft ISP. Therapeutic recommendations related to Supports for Daily Life may or may not be accepted by the person. Therapists should discuss potential alternatives and/or potential consequences of not addressing recommendations so that informed decisions can be made. Behavior service providers should review and discuss proposed behavior interventions in the draft behavior plan to ensure that the agencies, staff, or parents are able to carry out the proposed strategies and complete the necessary documentation. Refer to the Personal Outcome and Supports for Daily Life Tip Sheet in Appendix E12 for a description of goals for Supports for Daily Life and guidance in identifying goals.
6. Develop Actions needed to ensure successful attainment of outcomes and goals. The Planning Team must be in agreement that the Actions can be implemented and will likely result in attainment of the outcomes and goals. You cannot move forward in completing the plan until all concerns regarding Actions are resolved. Refer to the Actions Tip Sheet in Appendix E13 for guidance in developing actions.
7. Discuss any risk issues that have not already been addressed in the plan. Record these risks in number three (3) "Other Risks in This Person's Life" of the Action Plan part of the ISP. Therapeutic recommendations related to risks may or may not be included. Therapists should discuss potential alternatives and/or potential consequences of not addressing recommendations so that informed decisions can be made.
8. Develop actions needed to address, manage or alleviate these risks and record them in number three (3) "Other Risks in This Person's Life" of the Action Plan part of the ISP including the type, frequency and location of supports and services needed,

responsible person or entity and projected timeframes.
9. If the person does not have 24 hour supervision, the type of supervision the person needs must be included in number three (3) "Other Risks in This Person's Life" of the Action Plan part of the ISP. Also, the "Personal Focus" should include general information about when the person does not have supervision.
10. Develop actions needed regarding the person's supervision needs or associated risks including the type, frequency and location of supports and services needed, responsible person or entity and projected timeframes. Record these in number three (3) "Other Risks in This Person's Life" of the Action Plan part of the ISP.
11. If the person receives 24 hour supports but can spend any time alone, the amount of time, circumstances, location, conditions, etc. the person can be alone must be included in number three (3) "Other Risks in This Person's Life" of the Action Plan part of the ISP. Also, the "Personal Focus" should include general information about when the person does not have supervision.
12. Discuss supports for non-routine events. Record these in number four (4) "Supports for Non-Routine Events" in the Action Plan part of the ISP. These are events that vary from the person's regular routine and can be reasonably planned for in advance. Examples of supports for non-routine events include vacations, travel, visiting family, job loss, school closure, hospitalization, illness, crisis, respite, etc. Use the person's past history, current life events, expected life events, information provided by others, school schedule, health status, mental health stability, etc. to project any needs for the next year that cannot be specifically scheduled in advance.
13. Identify actions needed to support the non-routine event including the type, frequency and location of supports and services needed including special equipment, technology, treatment, etc. Record these in number four (4) "Supports for Non-Routine Events" in the Action Plan part of the ISP.
14. Discuss any planning meeting follow up issues that cannot be resolved in the meeting and cannot result in specific outcomes, goals or actions. Record these in number five (5) "Planning Meeting Follow-Up Issues" in the Action Plan part of the ISP.
15. Discuss the services that will be needed by the person in order to carry out the outcomes, goals and actions in the ISP as well as address any risk concerns and needs for non-routine events. Therapeutic services should be considered when use of these services is necessary to assist the person in overcoming a barrier to achieving a Personal Outcome or goal for Supports for Daily Life, to address health and safety issues or to manage identified risks. Refer to "Possible Indicators for Therapeutic Services Assessments" guide included in Appendix C3.
16. Review and finalize the first page in the Services and Supports section of the ISP. This section identifies the supports and services that are being used, or are required to meet the needs of the person.
17. Review and finalize the second page in the Services and Supports section of the ISP. The need for the services requested in this section must be supported in the ISP.

There must be evidence that the requested services will result in benefit to the person, what that benefit will be and how we will know that benefit occurred. For each service requested include the following information:

a. Service name such as ISC, personal assistance, physical therapy, etc.
b. Type of request using the code at the bottom of the page;
c. Tier (Level of Need/Tier);
d. Service Code as provided by DMRS;
e. Funding Source such as Waiver or State;
f. Provider Name;
g. Provider Code as provided by DMRS;
h. Site Name as assigned by DMRS;
i. Site Code as assigned by DMRS;
j. Start Date;
k. End Date;
l. Unit Rate;
m. Unit Type;
n. Number of Units including the frequency; and
o. Cost (total number of units x cost per unit).

Do not complete the section marked "DMRS Use Only". Page three (3) of this section of the ISP is also for DMRS use only. Do not mark in this section.

*Note: Some State Funded services may be requested by the Res/Day provider and may not be included on the Section C of the ISP. These requests need to be made to correspond with the time frame of ISP implementation.

18. If the person has a behavior plan, please indicate this in the Behavior Support Plan section of the ISP and attach the "What I do To Carry Out This Plan" developed by the behavior support provider.

19. Everyone attending the meeting should sign the "Planning Meeting Signature Sheet". Make sure the person or the person's legal representative understands that the ISP will be implemented as discussed in the meeting unless he/she notifies the ISC prior to the effective date of the plan.

20. Therapeutic services providers should finalize the Therapeutic Services Plan of Care after the planning meeting and obtain physician's orders if required. Physician's orders and the finalized Therapeutic Services Plan of Care must be forwarded to the ISC prior to submission of the ISP to DMRS for review and authorization of services. See a sample Therapeutic Services Plan of Care in Appendix C4.

21. Submit the plan to DMRS for review and authorization of services at least 21 days prior to the effective date. Include any required supporting documentation such as physician's orders, budgets, etc.

22. Distribute the final plan to all involved service providers so that it can be implemented on the effective date of the plan.

Other Important Things To Know:

- The ISP must be an accurate reflection of the person's wants and needs. Any contradictory information should be resolved and accurately recorded in the ISP.
- It is critical that providers are prepared for the planning meeting and fully participate in planning for services.
- It is critical that services, outcomes and actions are integrated throughout all aspects of the person's life as appropriate.
- If more than one provider is assigned responsibility for an outcome or action, both providers should work together to ensure successful implementation.
- Risk Issues that are not being addressed in the Action Plan section must be documented on the Risk Assessment Planning Tool included in Appendix C2.
- If therapeutic services are needed but the physician's order is not available at the time the plan is submitted, the service cannot be requested. The need for the service(s) should be included in the personal focus section of the plan, but outcomes, actions and the actual request for the service should not be included. It is acceptable to discuss and plan for the services at the planning meeting and then include them in an amendment once the physician's order is obtained.
- Therapeutic services do not take the place of direct services. They do provide a mechanism for developing therapeutic based goals and actions, training of staff to implement those goals and actions and oversight to ensure they are effective.
- While there may be times when an ISC/CM may find it appropriate to use therapeutic service goals from the POC as the actual actions in the ISP, it is not required that they do so. It is the ISC/CM's responsibility to facilitate discussion about the recommended goals during the planning meeting in order to assure they can be carried out in the manner in which they were recommended and are assigned to the appropriate responsible parties in order to assure that they are integrated into the person's day to day life.
- If a provider cannot be located, services should be requested and the person should be assisted in filing a delay in service appeal.
- There must be at least one outcome, goal or action for each service requested with the exception of Independent Support Coordination, Transportation for Personal Assistance, Establishment and MR Housing.
- ISPs should not contain required or suggested staffing ratios. The plan should identify the person's needs, outcomes, goals and actions. Providers determine staffing patterns needed to ensure the person's needs are met and that the ISP is fully implemented.

Provider Manual References:

- Chapter 3 "Individual Support Planning and Implementation"
- Chapter 12 "Behavioral Health"
- Chapter 13 "Therapy Services"
- Chapter 14 "Therapy Related Services"
- Chapter 15 "Nursing, Nutrition, Vision and Dental Services"

Resources

- ISC & CM Documentation Forms "Annual ISP Review and Update Preparation" Sample (Included in Appendix G & H)
- Technical Assistance Manual for Therapeutic Services
- Technical Assistance Manual for Behavior Services Providers
- Residential Services Handbook
- Day Services Handbook
- Personal Assistance Resource Manual

Training

- ISP Overview
- ISC Training
- Technical Assistance is available from the Regional Therapeutic and Behavior Services teams by request.

SECTION SIX
BEHAVIOR SUPPORT PLANNING

What: When a behavior need is assessed and the individual and others on the team feel that the current behavior is presenting a risk to others or a barrier to a person fully participating in home and community life. Some behaviors present an obvious danger to the person, such as running into moving traffic. Other behaviors may present some barriers due to their high frequency or excessive use, such as hugging strangers. A behavior plan is designed to be part of the total plan of care and to get a good behavior plan you have to work with all the other team members in putting together a behavior plan that works with the total Individual Support Plan. The behavior plan has to work in all environments where the behavior is occurring. Staff, and sometimes family members, are the people who carry out the plan and the most successful plans are the ones that take into consideration the ideas of the individual and the people who will carry out the plan.

The elements for a successful and effective behavior plan are:

- That the person and everyone involved is on the same page about why behavior intervention has been proposed and what steps are going to be taken to carry out the plan;
- The plan is written in a clear and concise manner so that everyone who refers to the plan can understand it;
- The plan is written in a way so that everyone knows what they have to do and who is responsible for what. It must clearly indicate who is to be contacted if the plan starts out being very effective and then later needs more attention;
- The plan has a title, "What I Do To Carry Out This Plan" and includes at least sections on what to do to increase positive replacement behavior, what to do to decrease behavior, what not to do, and what to document.

The document titled "What I Do To Carry Out This Plan" is the document that is embedded in the ISP.

There are two types of behavior plans: a behavior support plan and a behavior maintenance plan.

The behavior support plan focuses in on decreasing the challenging behaviors and increasing the more appropriate replacement behaviors. It is designed to get behavior changes. If behavior changes do not occur, the plan may need to be adjusted. Sometimes that might mean an ISP amendment is needed.

The behavior maintenance plan serves as a plan for the natural settings to sustain successful interventions so that the person can maintain or make even more

progress. A behavior maintenance plan is successful if the level of challenging behaviors and replacement behaviors remains stable as the behavior analyst and behavior specialist reduce the behavior services. The idea is that the community environments have changed enough and are consistent enough to help the individual maintain his or her progress. The final goal is for the person to be able to be successful in all environments without the need of a behavior plan.

The behavior analyst is responsible for writing the behavior plan, for monitoring achievement of measurable objectives and for adjusting the plan as needed. The behavior analyst monitors and reports progress on the Clinical Service Monthly Review Form located in Appendix F3.

The behavior specialist works with the behavior analyst to train staff and observe progress.

The community agencies support the implementation of the plan by providing a management and supervisory structure.

The direct support professionals use their skills to carry out the plan that is expected to reduce the challenging behavior and to increase the replacement behavior.

The ISC/CM, the individual and other members of the team report on the way the plan is going and request help if the plan is not going well.

Who: The individual, the ISC/CM, the Circle, and the community agencies that shall be responsible for implementing the plan and other members of the planning team listen to the plan proposed by the behavior analyst and offer input. It is important to have everyone on the same page, since a behavior plan needs the buy in from all these people to really be effective.

The individual and/or legal representative provides informed consent for the plan.

Each behavior support plan and behavior maintenance plan is reviewed by a Behavior Peer Review Committee and/or the Behavior Support Committee, which helps ensure the quality of the plan.

Behavior analysts emphasize positive behavior supports in their behavior plans, and many individuals are very successful in gaining important replacement behaviors as alternatives to the challenging behavior they used before a behavior support plan was in place. These plans rely on interventions that emphasize the increase in positive behaviors and use interventions that are labeled "unrestricted interventions." For a few complex individuals, a behavior support plan may require some additional interventions because previous plans were unsuccessful or because

the challenging behaviors have become very dangerous and a serious risk. Some behavior support plans may involve consequences that are viewed as restricted interventions, and these plans need to reviewed by both a Behavior Peer Review Committee and/or a Behavior Support Committee and a Human Rights Committee.

Some special behavior support plans may involve interventions or consequences that have not been designated by DMRS as unrestricted or restricted interventions. If the planning team and the person agree that these interventions are needed, additional approval would be needed from the DMRS Central Office.

When: The consideration for a plan begins with the behavior assessment. A plan may be considered if there is a need to help to develop alternatives to challenging behaviors that are presenting a serious barrier to community life or health or safety risk to the person or others. The proposed interventions should be discussed and resolved at the planning meeting. The expectation is that the assessment will be developed within 30 days of the authorized start date of the assessment and that the plan will be developed and trained within 30 days of the authorized start date of the plan development/initial training.

Process:

What Happens	Who Is Responsible
1. Complete the behavior assessment. If behavior services including a behavior plan is needed, describe the suggested interventions that will be part of the plan, and the behavior objectives for the plan	• Behavior Analyst
2. Request authorization for behavior services	• ISC or DMRS Case Manager
3. Upon authorization of behavior services, develop the plan, obtain informed consent, present to relevant committees, and train the plan	• Behavior Analyst

Other Important Things to Know:

- The behavior support plan and the behavior maintenance plan must be integrated with the ISP and its person centered Outcomes.
- The proposed interventions must be reviewed at the Planning Meeting, and adjustments may be made in the propose plan based upon input from the team.
- Actions related to the behavior services shall be functional and measurable.
- The behavior support plan and the behavior maintenance plan shall include one or more specific behavior objectives.

- The behavior analyst monitors and reports on the effectiveness of the plan each month using the Clinical Service Monthly Review. Progress on the objectives is recorded each month and behavioral graphs are included in the monthly reviews.

  If progress is not made, or the challenging behaviors become more dangerous, the behavior analyst addresses these issues. The behavior analyst may contact the residential or day habilitation agencies to understand the issues, and may need to do additional training with the people carrying out the plan. In some cases it may be necessary to add more behavioral procedures, including a restricted intervention. Whenever a restricted intervention is being considered or additional criterion are added to a restricted intervention already in a plan, the plan and possible revisions must be discussed by the team. Upon approval of the revised plan, the ISP is be amended to accommodate the revised plan.

Provider Manual References
- Chapter 12 Behavioral Health
- Chapter 3 Individual Support Planning and Implementation
- Chapter 2 Individual Rights

Resources:
- Clinical Service Monthly Review (Appendix F3)

Training or Technical Assistance:
- New Behavior Provider Orientation
- Monthly Regional Behavior Seminar Meetings with Behavior Providers facilitated by Central Office
- Other Technical Assistance as needed

SECTION SEVEN
INDIVIDUAL SUPPORT PLAN REVIEW AND SERVICE AUTHORIZATION

What: Individual Support Plans must be submitted to DMRS Regional Plan Review staff and requested services authorized prior to implementation.

Who: DMRS Plan Review Staff
DMRS Therapeutic Services Staff
DMRS Case Managers (For Individuals Enrolled in the Self Determination Waiver)
Independent Support Coordinator (For Individuals Enrolled in the Arlington or Statewide Waiver)
Agency Case Managers (For Individuals receiving State Funding only)
Day and Residential Providers (For identified State Funded Requests for individuals receiving waiver funding)

When: Initial Individual Support Plans must be developed within thirty (30) calendar days from the date of enrollment and should be submitted to the appropriate Regional Office as far in advance of that date as possible.

Annual Individual Support Plans must be submitted to the appropriate Regional Office at least twenty-one (21) days prior to the effective date.

Amended Individual Support Plans must be submitted at least twenty-one (21) days prior to the effective date.

Urgent requests for services in an initial, annual or amended Individual Support Plan can be made by submitting the plan as "Urgent" or if the approval is needed during non-business hours, a request can be made using the Administrator on Duty (AOD) pager system. In these circumstances, authorization can be made at the time the call is placed. An amendment must be submitted as "Urgent" on the next business day.

Process:

What Happens	Who Is Responsible
1. Complete Individual Support Plans and required supporting documentation are submitted to the appropriate regional office within the timelines stated above.	• ISC or DMRS Case Manager
2. The plan is reviewed to ensure requested services are justified by the plan.	• DMRS Plan Review Staff

3. Each service requested is reviewed. Regional Therapeutic, Nursing and Behavioral Services staff may provide technical assistance to Plan Review Staff as requested. Services may be denied or partially approved if they meet one or more of the following conditions: ▪ There is no evidence in the plan that the requested service is needed. ▪ There is no evidence in the plan that the level of service requested is needed. ▪ There is no outcome, action or support goal to indicate the expected benefit of the requested service. ▪ The service is not being requested in accordance with current State and Medicaid Waiver definitions. ▪ The service requested has exceeded the benefit limit. ▪ Required supporting documentation is not provided. In these circumstances, services cannot be fully approved until corrections are made.	• DMRS Plan Review Staff
4. If a plan needs corrections, it will be returned to the ISC or DMRS Case Manager with a brief explanation of the corrections needed and the expected timeframe for a reply.	• DMRS Plan Review Staff
5. The plan should be returned within the requested timeframe to prevent delays in service.	• ISC or DMRS Case Manager
6. If the services requested are denied or partially approved, the recipient along with the ISC or DMRS case manager will be notified via written denial from the Regional Office ▪ The written denial will explain the reasons why the requested service was denied and will explain how to file an appeal.	• DMRS Plan Review Staff • DMRS Appeals Staff
7. The appeal must be submitted within 30 days of receipt of the denial.	• ISC or DMRS Case Manager on behalf of the person • Legal Representative

Other Important Things To Know:

- DMRS may recoup full payment for ISC services from Independent Support Coordination Providers each time an ISP is not submitted timely.
- If a physician's order is required for the service being requested but it is not available at the time the plan is submitted, the service will not be able to be approved. The need for the service(s) should be included in the personal focus section of the plan, but outcomes, actions and the actual request for the service should not be included. It is acceptable to discuss and plan for the services at the planning meeting and then include them in an amendment once the physician's order is obtained.
- Therapeutic services do not take the place of direct services. They do provide a mechanism for developing therapeutic based goals and actions, training of staff to implement those goals and actions and oversight to ensure they are effective.
- If a provider cannot be located, services should be requested and the person should be assisted in filing a delay in service appeal.
- There must be at least one outcome, goal or action for each service requested with the exception of Independent Support Coordination, Transportation for Personal Assistance, Establishment and MR Housing.
- ISPs should not contain required or suggested staffing ratios. The plan should identify the person's needs, outcomes, goals and actions. Providers determine staffing patterns needed to ensure the person's needs are met and that the ISP is fully implemented.

Other Important Things to Know About Appeals:

- The Regional Office can help with any additional assistance needed to file the appeal. Recipients with Limited English Proficiency will have the opportunity to request translation assistance for their appeal.
- If you are currently receiving the appealed service through DMRS or DMRS cut or stopped the care that you are asking for, you may be able to continue to receive the service pending your appeal (Continuation of Benefits –COB). This request must be submitted within 10 days of your receipt of the Regional Office denial or termination letter.
- Usually, an appeal is resolved within 90 days after it is filed. But, if there is an emergency, this may be too long for you to wait. An emergency appeal is usually resolved within 31 days (but sometimes up to 45 days).
- If an emergency appeal is needed (*an emergency appeal* is *defined as* a *risk of serious health problems, risk of death, possibly causing serious problems with the heart, lungs or other parts of the recipient's body or having to go into the hospital*) then the appeal form can be filled out as an emergency appeal, which has an area included for your doctor's signature.
- Your appeal may go faster if your doctor signs your appeal saying that it is an emergency**.** What if your doctor doesn't sign your appeal, but you ask for an emergency appeal? TennCare will ask your doctor if your appeal is an emergency. If your doctor says it's **not** an emergency, TennCare will decide your appeal within 90 days.

- Day and Residential Providers may submit service requests for some state funded services outside of the ISP for individuals who receive Waiver funding. These requests follow the same process for submission through the Plans Review Unit.

Provider Manual References:
- Chapter 3 "Individual Support Planning and Implementation"
- Chapter 12 "Behavioral Health"
- Chapter 13 "Therapy Services"
- Chapter 14 "Therapy Related Services"
- Chapter 15 "Nursing, Nutrition, Vision and Dental Services"

Resources
- Technical Assistance Manual for Therapeutic Services
- Residential Services Handbook
- Day Services Handbook
- Personal Assistance Resource Manual

Training
- ISP Overview
- ISC Training
- Technical Assistance is available from Regional Office Plans Review Staff upon request.

SECTION EIGHT
IMPLEMENTATION AND DOCUMENTATION OF THE INDIVIDUAL SUPPORT PLAN

What: Providers are responsible for implementing the Individual Support Plan. Documentation of the person's progress in meeting established outcomes and actions ensures that services are modified when needed and supports the person's achievement of a satisfying and healthy life.

Evidence that the plan has been implemented is crucial to support billing and payment for services provided.

Who: Providers (Residential, Day Services, Personal Assistance, Therapeutic Services, and anyone else who provides a direct service to the person as identified in the ISP)
Therapeutic Services Providers
Behavior Services Providers
DMRS Case Managers (For Individuals Enrolled in the Self Determination Waiver)
Independent Support Coordinator (For Individuals Enrolled in the Arlington or Statewide Waiver)

When: Once a plan is completed and services are authorized to begin.

A. Process: General Implementation Information

What Happens	Who Is Responsible
1. The ISP must be on-site where services are being provided.	• Providers
2. Adequate staff must be available to carry out the plan for each person being served.	• Providers
3. If an action plan requires detailed instructions to staff, these should be written as a reference for staff to follow after any initial training has occurred. See Appendix I for Staffing Instruction samples.	• Providers
4. Appropriate activities should be developed to facilitate implementation of each action.	• Providers
5. 5. The development of schedules may be created for staff to follow to help ensure that actions are implemented as specified in the ISP.	• Providers
6. Implementation activities related to	• Providers

implementation of the ISP along with the person's day to day routine activities should be coordinated with therapeutic services providers, nurses, behavior services providers, the person, the person's family, direct support professionals and others involved in supporting the person.	
7. All staff involved in supporting the person must be trained on each person's ISP and how to carry out the actions as specified in the ISP.	• Providers
8. Documentation must be maintained for all activities performed as they relate to implementation of the plan. This documentation must be maintained in a manner that indicates the person's progress or lack of progress in achieving the identified actions, outcomes and goals in the plan.	• Providers
9. Progress toward achieving actions, outcomes and goals must be reported monthly. The documentation of this must be forwarded to the ISC or DMRS Case Manager by the twentieth day of the month following that month for which the review was completed. See Appendix F2 for a sample Monthly Report Form.	• Providers
10. If there are problems with implementing the plan as written, if the person is not making progress, if the person is regressing, if the person is resisting implementation or if any other changes are needed, the ISC or DMRS Case Manager must be contacted and the plan amended if appropriate.	• Providers • ISC or DMRS Case Manager

B. Process: Staff Training

Note: All providers are responsible for implementing all the activities in this section.

What Happens
1. Staff must be trained to implement the ISP and document activities related to implementation within thirty (30) days of the effective date of the ISP.
2. Staff training must occur initially and anytime there is a change in the ISP or new equipment is delivered and training is needed beyond that routinely provided by

the manufacturer or equipment provider.
3. Training provided must be competency based. In other words, staff must be observed implementing the ISP correctly including proper use of any needed equipment or supplies.
4. Training must include why the plan is to be implemented, how it is to be implemented and how it will help the person achieve ISP outcomes, actions and goals within the framework of health and safety.
5. If a therapeutic services provider is providing the training, it must be appropriately documented including the training content, the names of staff being trained, the dates training sessions occurred and each staff person's performance and competency level. Providers must record training information in accordance with the provider manual requirements for training specific to the person.
6. Training should be coordinated between the provider, therapeutic services provider and others who support and know the person.
7. The provider and therapeutic services provider must work together to identify and train a designated trainer within the agency to provide ongoing staff training to new/replacement staff.
8. Designation of a "trainer" may not be appropriate if the person's health status is unstable, if frequent changes in specific methodologies are required or if implementation methodologies are particularly complex. In these cases, the therapeutic services provider may be the most appropriate provider to manage ongoing staff training.
9. The reason(s) that a therapeutic services provider must provide ongoing staff training must be thoroughly documented in either therapy contact notes or therapy monthly reviews. The therapeutic services provider must continue to reassess for changes in the situation that would allow designation of a trainer employed by the provider of the direct support staff who will carry out the ISP. These ongoing reassessments are to be documented in therapy monthly reviews.
10. Behavior Services Providers provide training on implementation anytime a new plan is started, anytime an ongoing plan is revised and anytime the performance of the person implementing the plan falls below 80%.
11. The behavior analyst responsible for the plan may train the person(s) who will carry out the plan. Where possible, the behavior analyst should determine that the stability of the behavior and the conditions are adequate to train an agency staff person or a behavior specialist to train others on the plan.
12. The behavior analyst may determine that he or she needs to do the training directly when: ▪ The behavior plan is in the early phases of implementation and adjustments may be necessary; ▪ The behavior plan is very complex; ▪ Behaviors are at a very high frequency, intensity or are rapidly changing; ▪ There is turnover of staff and the agency trainer is no longer available; or

▪ When doing direct observations it is discovered that the staff person observed is not carrying out the plan correctly.

C. Process: Staff Instructions
Note: All providers are responsible for implementing all the activities in this section.

What Happens
1. There are times when it is important to provide staff with specific instructions that outline the activities, methodologies or steps they need to employ in order to successfully complete a specific action in the ISP. These are called staff instructions. Staff instructions are completed after the ISP is completed and within 30 days of initiation. See Appendix I1 for Staffing Instruction sample form.
2. Staff instructions are most likely needed when: ▪ An action involves an activity requiring multiple steps that need to be completed in a specific order; ▪ An action requires absolute consistency to ensure successful implementation; ▪ An action requires coordination with clinical professional services; or ▪ An action requires a complex set of activities, actions or activities.
3. Staff instructions are most likely not needed when: ▪ An action is specific in and of itself and no specific instructions for implementing the action are needed; or ▪ An action is going to be carried out by a professional such as a therapeutic services provider, counselor, nurse or physician.
4. Staff instructions must be individualized and person-centered. They must take into account the person's preferences, daily schedule, other needs, etc.
5. Staff instructions must be written in clear, simple and concise language.
6. Staff instructions may include: ▪ The person's name; ▪ The date; ▪ The funded services; ▪ The outcome statement or goal from the ISP; ▪ The action from the ISP; ▪ A detailed description of the method that will be used by staff – what staff are expected to do – to implement the action; ▪ Who is responsible – the person(s) ultimately responsible for assuring the Staff Instructions are implemented correctly; ▪ Frequency the instructions are to be implemented; and ▪ The documentation that is needed to track progress.
7. For therapeutic or behavioral interventions, staff instructions will be developed by the therapeutic services provider/behavior analyst in conjunction with the direct support staff or other staff as identified by the residential or day provider. Residential and day providers are responsible for all others.

8. Staff instructions must be modified anytime there is a change in the person's outcomes, actions or goals or there is a need to change to methodologies, activities or sequence of events needed to ensure successful implementation of the action.

D. Process: Staffing Plans – Residential Providers (Residential Habilitation Services, Family Model Residential Supports, Medical Residential Services and Supported Living Services)

Note: Residential Providers are responsible for implementing all the activities in this section.

What Happens
1. Staffing plans are developed prior to the ISP Planning Meeting for persons already receiving services or subsequent to the ISP Planning Meeting for persons new to the provider or at any time the needs of the individual's in the home change significantly.
2. Staffing plans must be available in each home to provide direct support staff information regarding who is to be responsible for service provision for each staffing period or shift. An example of a Staffing Plan Form is in Appendix I2
3. Adequate staff must be available to carry out the plan for each person being served.
4. Review the person's ISP and documentation from staff concerning the needs of the individual's in the home.
5. Staffing plans must reflect: ▪ Compliance with staffing standards specified in licensure regulations; ▪ Adequate numbers of trained staff to implement the ISP and ensure the health and safety of service recipients; ▪ Efficient use of staff to cover peak and overnight hours; ▪ Availability of back-up and emergency staff when scheduled staff cannot report to work; ▪ Presence of at least one staff person when the person is in the home unless the ISP allows less than 24 hour supervision and details the type of specific support needed and all requirements for the person's safety in the absence of a staff person are met. In this situation, how to access staff should be clearly defined; and ▪ For individuals who are receiving Medical Residential Services, an LPN must be on site whenever an individual is in the home.
6. It is recommended that staffing plans clearly delineate the reasons for the decisions about how the home is staffed. A narrative can be a good way to explain why particular individuals need attention for certain activities, when extra staff is needed and why.
7. It is recommended that staffing plans clearly indicate where staff can find more detailed information about the person's ISP, outcomes, goals, actions, staff instructions, etc.

8. Staffing plans should be reviewed and revised as necessary when a new person moves into a home or when there is a significant change in any person's condition.
9. Staffing plans may be expanded to address implementation tasks for which direct support staff is responsible. This clearly communicates the agency's commitment to implement ISPs, can also communicate expectations to staff and may provide the basis for documentation of what staff has done with and for the person. Options for expanding staffing plans include: ▪ A Daily Task List for the home that is based on the person's ISP. ▪ A Weekly Schedule for the home based on the person's ISP using activity related segments rather than times or time periods. ▪ Staff "Job Plans" that identify specific activities to be completed with individuals in the home.
10. A narrative explanation about the reasons for the decisions on how the home is to be staffed should be included in the plan.
11. Several residential rates have specific requirements already tied to them. These requirements must be reflected in the staffing plan.

E. Process: Staffing Plans – Day Services Providers

Note: Day Services Providers are responsible for implementing all the activities in this section.

What Happens
1. A staffing plan must be developed for each day service provided. Staffing plans are developed prior to the ISP Planning Meeting for persons already receiving services or subsequent to the ISP Planning Meeting for persons new to the provider or at any time the needs of the individual's in the day service change significantly.
2. Staffing plans must be kept in provider administrative offices along with documentation to support that the staffing plan was followed.
3. Review the person's ISP and documentation from staff concerning the needs of the individual(s) supported.
4. Staffing plans must ensure: ▪ Compliance with applicable licensure standards; ▪ Adequate numbers of trained staff to implement the ISP and ensure the health and safety of service recipients; and ▪ Availability of back-up and emergency staff when scheduled staff cannot report to work. ▪ Presence of at least one staff person when the person is in the home unless the ISP allows less than 24 hour supervision and details the type of specific support needed and all requirements for the person's safety in the absence of a staff person are met. In this situation, how to access staff should be clearly defined.
5. It is recommended that the provider develop a staffing plan based on the needs of the group of individuals working together and their goals and outcomes rather

than a single one for the entire facility.
6. It is recommended that staffing plans clearly indicate where staff can find more detailed information about the person's ISP, outcomes, goals, actions, staff instructions, etc.
7. It is recommended that the staffing plan for each group clearly portray the reasons for the decisions about how the service is staffed. A narrative is a good way to explain why particular people need attention for certain activities, when extra staff is needed and why.
8. Staffing plans should be reviewed and revised as necessary when a new person moves into the group or when there is a significant change in any person's condition.
9. Staffing plans may be expanded to address implementation tasks for which direct support staff is responsible. This clearly communicates the agency's commitment to implement ISPs, can also communicate expectations to staff and may provide the basis for documentation of what staff has done with and for the person.
10. Several day service rates have specific requirements already tied to them. These requirements must be reflected in the staffing plan.

F. Process: Direct Hands-On Clinical Interventions

Note: Therapeutic Service Providers are responsible for implementing all the activities in this section.

What Happens
1. There are times when a therapeutic services provider may provide time limited direct service to a person. These are called "Direct Hands-On Clinical Interventions".
2. Direct Hands-On Clinical Interventions are intended to assist individuals in accomplishing identified outcomes and actions in their ISPs.
3. Examples of issues that may require time limited Direct Hands-On Clinical Interventions include: ▪ Limited communication; ▪ Sensory processing disorders; ▪ Limited mobility; ▪ Limited independence or safety during activities of daily living; ▪ Difficulty following doctor-prescribed diets; and ▪ Limited mobility and independence due to visual impairments.
4. Direct Hands-On Clinical Interventions must be based on functional and measurable actions included in the person's ISP.
5. Direct Hands-On Clinical Interventions must require the skill of a therapist to accomplish such functional changes as improved mobility, reduced self-stimulatory or self-abusive behavior, improved communication skills, and improved gross or fine motor skills for functional tasks.

6. Direct Hands-On Clinical Interventions may also be directed at conducting trials of assistive technology or adaptive equipment in order to assist a person in obtaining the necessary equipment identified in the assessment. Tolerance testing of equipment may be necessary in order to assure that the person is able to tolerate such equipment as a new wheelchair/seating system, alternative positioning, splints, orthotics, etc. This can be set up as an activity for staff to carry out. Other functional activities should occur during the time in which tolerance testing is taking place.
7. During the provision of Direct Hands-On Clinical Interventions, it may be necessary and appropriate for certain services to be provided concurrently in order to integrate strategies and supports. "Co-treatment" is not a goal or outcome; it is an intervention and therefore, does not have to be incorporated into the action plan of the ISP.
8. When "co-treatment" is deemed necessary, both therapeutic services providers involved must be sure to document the need for it in their clinical contact note.
9. "Co-treatment" should be time limited but may occur at various times during the year as the individual changes in relation to the interventions.

G. Process: Consultation

Note: Therapeutic Service Providers are responsible for implementing all the activities in this section.

What Happens
1. When the clinician begins to phase out direct services and work with direct support professionals to integrate individual support needs into the individual's daily life it is called consultation. Integration of supports throughout the person's day promotes independence as well as minimizes or prevents associated health conditions. Supports and services for an individual throughout the 24-hour day and 7-day week maximize the person's functional abilities and potentials throughout their natural environments and considers all aspects of a person's preferences, interests and lifestyle. A strong partnership between the individual receiving services, the therapeutic service provider, and the people supporting the individual on a day to day basis is crucial to the success of any recommended supports and services. As service needs are integrated into the individual's daily life, the therapeutic services provider shifts into a consultative role that provides support and promotes brainstorming when problems arise.
2. The following are critical components for promoting the integration of supports and services throughout a person's day: ▪ staff knowledge and competence related to providing positioning and alignment opportunities for individuals throughout their day while using lifting and transfer techniques which prevent staff injury as well as injury of the person; ▪ staff knowledge and handling skills related to providing movement opportunities

for individuals;

- staff understanding of the impact that diet texture and consistency have on eating and swallowing;
- proper use of specialized mealtime assistance techniques with individuals that insure safety, improve eating and drinking skills, and promote optimal levels of independence at mealtime;
- proper use, care and maintenance of specialized assistive technology and adaptive equipment;
- competency-based training specific to the needs of the individual available from within a residential/day agency by a designated trainer; and,
- a well-integrated approach to monitoring and documenting individual progress to ensure that problematic issues are recognized by support staff and communicated to the clinician.

H. Process: Documentation

Note: All Providers are responsible for implementing all the activities in this section.

What Happens
1. DMRS has no required forms for documenting implementation of the ISP.
2. Good documentation includes: ▪ A comprehensive picture of what has occurred and progress that has been made; ▪ Details how often data will be taken; ▪ Tracks frequency of implementation; ▪ Supports the provider's responsibility to report on the person's reaction to various activities or methodologies; ▪ Supports the provider's responsibility to report progress toward accomplishing a particular outcome, action or goal in a consistent way; and ▪ Supports the provider's responsibility to complete monthly reviews.
3. Residential and Day service providers must complete documentation. Documentation should include but is not limited to: ▪ Evidence of the provision of the approved service; ▪ Implementation of outcomes, actions or goals; ▪ Communication of significant information about daily events that is important for all staff to know such as medical events, behavioral events or other unusual events that occurred for the person. ▪ Contacts made by other service providers; etc. The monthly documentation requirements for Residential and Day services providers is a monthly review which is a summary of the ISP implementation and events occurring with or on behalf of the person during the given review month. Monthly documentation includes recording progress on completing actions and reaching

desired outcomes See Appendix F for additional information about Documentation criteria.
4. Therapeutic services providers must complete a contact note each time a visit is made with the person. This contact note should include: ▪ Details regarding the specific ISP action, outcome or goal being addressed; ▪ Services provided; ▪ The time-in/time-out for the visit; ▪ The person's response to the session; ▪ Any training provided; and ▪ Any other pertinent information.
5. Direct support professionals must document the presence of any therapeutic service provider in the person's communication notes.
6. Clinicians (therapists, not therapy assistants) are also responsible for providing a face-to-face monthly reassessment of services and producing a corresponding written monthly review of services. The monthly review should detail the services provided for the month and an analysis of the impact these services had on the individual's progress. Missed visits and the reasons for any missed visits should be detailed in the monthly review as well as any recommendations for changes to the POC/ISP including any changes in the number of units needed for services. Providers should indicate any barriers to the implementation of the ISP in the monthly review as well as discuss them with the appropriate provider and the ISC/DMRS Case Manager.
7. Behavior Analysts complete on-site observations and reports progress and implementation information. Behavior Specialists, as applicable, may complete on site observations and provide information to the behavior analyst. A Clinical Contact Note should be completed and include information about the purpose of the visit, any problems with implementation, increased levels of risk or regression and actions taken. A Clinical Service Monthly review summarizes the findings from the on-site visits and is completed by the Behavior Analyst and forwarded to the ISC/DMRS Case Manager by the 20th day of the following month. See Appendix F3 for a sample Clinical Service Monthly Review.

Other Important Things To Know:

- When needed, staff instructions must be developed within 30 days of the initiation of services.
- Most often for therapeutic and behavior services, the actions will be a collaborative effort between the clinician and the residential and day service provider's direct support staff and staff instructions will be needed.
- When an action is a one-step task and no additional details are required for its completion, staff instructions are typically not needed.
- Developing a staff schedule for a home or day services location/grouping is not a requirement, but can be helpful in providing guidance to Direct Support Professionals as

well as ensuring implementation of the ISP. See Appendix I for additional information and example form.

- All therapeutic services must be provided face to face with the individual in order to be billed, with the exception of nutrition and orientation and mobility services. These two services can be provided just with the person's staff *for the purposes of training* when necessary and appropriate.
- Adequate evidence that services are provided is critical to support billing and subsequent payment for services rendered.

Provider Manual References:

- Chapter 3 "Individual Support Planning and Implementation"
- Chapter 6 "General Provider Requirements"
- Chapter 9 "Residential Services"
- Chapter 10 "Day Services"
- Chapter 12 "Behavioral Health"
- Chapter 13 "Therapy Services"
- Chapter 14 "Therapy Related Services"
- Chapter 15 "Nursing, Nutrition, Vision and Dental Services"

Resources

- Technical Assistance Manual for Therapeutic Services
- Day Services Handbook
- Employment Services Handbook
- Residential Services Handbook
- Personal Assistance Resource Manual

Training

- Challenges in Physical Management, Mealtime Challenges, Enhancing Independence in Physical Management, and Enhancing the Mealtime Experience courses are offered by the Regional Therapeutic Services Teams and are geared at providing foundational training for direct support staff, personal assistants, and others for carrying out staff instructions related to health and safety needs.
- Versions of the above listed courses are also offered specifically for clinicians providing services.
- Training on developing staff instructions is available from the Regional Office Training Department upon request.
- Staffing Plan Training is available by request through the DMRS Central Office.

SECTION NINE
MONITORING IMPLEMENTATION OF THE INDIVIDUAL SUPPORT PLAN

What: Implementation of the Individual Support Plan is a continuous process that is critical to ensure that the ISP remains current, accurate and reflective of the person's needs.

Who: DMRS Case Managers (For Individuals Enrolled in the Self Determination Waiver)
Independent Support Coordinator (For Individuals Enrolled in the Arlington or Statewide Waiver)
Person, Family, Friends and Legal Representative
Providers (Anyone who provides services to the person as identified in the ISP)

When: Monitoring implementation of the Individual Support Plans is a continuous process in that anytime there are serious issues regarding implementation, they must be discussed and corrective action must be taken.

At a minimum, providers of direct service must review progress and report it monthly as part of the monthly review process

Independent Support Coordinators must review implementation of the ISP during their monthly face to face visit and review the person's progress toward meeting specific actions, outcomes and goals during the 3rd, 6th, and 9th month of the planning year.

DMRS Case Managers must monitor implementation of the ISP through their monthly contacts and assess progress at least once every 3rd month based on observations during the face to face visit and other available information.

Clinicians and Behavior Service Providers conduct periodic monitoring to ensure plans are being implemented as written and that the plan continues to be effective.

Process:

What Happens	Who Is Responsible
1. Once a plan is implemented, all providers who support the person and anyone else who cares about the person is responsible for monitoring the person's progress toward achieving his/her outcomes, goals and actions. See Appendix F	• Person, Family, Friends and Legal Representative • All Providers • ISC or DMRS Case Manager

for additional information on Documentation Criteria for residential, day and respite services.	
2. If a any provider, believes the person is not making progress, is regressing, is resisting implementation of the plan, that the plan no longer reflects his/her needs or otherwise needs modifications, they must notify the ISC or DMRS Case Manager and discuss the issues. In some cases, the issues may be resolved informally. In other situations, the issues may require a meeting and/or amendment to the ISP.	• All Providers
3. Providers must, at a minimum, review the delivery of services, documentation of progress on outcomes, goals and actions, etc. and report this information monthly to the ISC or DMRS Case Manager. See Appendix F for samples of Monthly Review forms.	• All Providers
4. Independent Support Coordinators must monitor implementation of the ISP during their monthly face to face visits. Since the Behavior Support Plan is part of the ISP, implementation of the Behavior Support Plan is included in this review. It is important that visits be made across all service delivery environments to ensure effective implementation of the ISP. During these visits they must observe any ISP implementation related activities and note whether or not they are being completed in accordance with the ISP, if all necessary equipment and supplies are available, etc. If they are not, issues must be reported to the responsible provider and the appropriate DMRS Regional Office using the Issues Reporting and Tracking Form. See Appendix H2 for an example of the ISC Issues Reporting and Tracking Form.	• Independent Support Coordinator
5. Every 3rd, 6th and 9th month, the ISC is responsible for reviewing the person's progress in meeting each outcome, goal and action. They are to review the ISP and ensure it continues to meet the person's needs and that it is reflective of the person's needs and	• Independent Support Coordinator

preferences. Since the Behavior Support Plan is part of the ISP, implementation of the Behavior Support Plan is included in this review. Any issues must be reported to the responsible provider and the appropriate DMRS Regional Office using the Issues Reporting and Tracking Form. See Appendix h for an example of the ISC Issues Reporting and Tracking Form.	
6. The ISC is responsible for facilitating meetings to address implementation issues and to amend the plan if appropriate. ISPs should be amended when: ▪ Outcomes, actions or goals change; ▪ Services or service providers change; ▪ There is a significant change in overall service and support needs; or ▪ The ISP is no longer reflective of the persons' needs and preferences.	• Independent Support Coordinator
7. DRMS Case Managers are responsible for ensuring the plan is being implemented on a monthly basis using information they obtain from contacts made with or on behalf of the person. Any issues must be reported to the responsible provider and the appropriate DMRS Regional Office using the Issues Reporting and Tracking Form. See Appendix G for an example of the Case Management Issues Reporting and Tracking Form.	• DMRS Case Manager
8. DMRS Case Managers are responsible for assessing the person's progress toward achievement of goals, outcomes and actions during every 3rd month. This assessment is based on their face to face visit and other information obtained from the person, family, provider or others. Any issues must be reported to the responsible provider and the appropriate DMRS Regional Office using the Issues Reporting and Tracking Form. See Appendix G for an example of the Case Management Issues Reporting and Tracking Form.	• DMRS Case Manager
9. Monitoring by the clinician promotes continued support and problem solving as issues arise as	• Therapeutic Service Providers

well as periodic monitoring to assure that staff instructions and other support needs are being carried out and continue to be effective. Data maintained by support staff is analyzed and any necessary changes are discussed, considered, and implemented as appropriate. Monitoring may continue at lengthening intervals for a period of time depending on individual needs. Discharge should occur once necessary strategies are adequately incorporated into a person's day and the person's status is stable.	

Other Important Things To Know:

- Monitoring implementation of the plan is a continuous process. Any serious or persistent issues regarding implementation should be addressed regardless of when they are identified.
- All providers are responsible for monitoring implementation of the plan and reporting any concerns with implementation or the need to amend the plan.
- Independent Support Coordinators and DMRS Case Managers have primary responsibility for ensuring the plan remains current, accurate and reflective of the person's needs.
- Standard documentation forms are used by Independent Support Coordinators and DMRS Case Managers to document and report all monitoring activities.

Provider Manual References:

- Chapter 3 "Individual Support Planning and Implementation"
- Chapter 12 "Behavioral Health"
- Chapter 13 "Therapy Services"
- Chapter 14 "Therapy Related Services"
- Chapter 15 "Nursing, Nutrition, Vision and Dental Services"

Resources

- ISC Documentation Forms (Included in Appendix H)
- DMRS Case Manager Documentation Forms (Included in Appendix G)
- Technical Assistance Manual for Therapeutic Services
- Day Services Handbook
- Residential Services Handbook
- Personal Assistance Resource Manual
- Documentation Criteria for Residential, Day, PA, Respite and Behavioral Respite Services included in Appendix F

Training

- ISP Overview
- ISC Training
- Regional Behavior Staff orientation for new providers and technical assistance